Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003611	A. BUILDING: _____ B. WING _____	R 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE SKIES HOSPICE INCORPORATED	2714 169TH ST HAMMOND, IN 46323

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 000}	INITIAL COMMENTS This was the revisit for the 2013 ISDH Sanitation Inspection based on the Retail Food Establishment Sanitation Requirements at 410 IAC 7-24 completed 8/27/13. Facility Number: 003611 Survey Dates: 11/6/2013 Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor Quality Review: Quality Review: Joyce Elder, MSN, BSN, RN November 8, 2013 Blue Skies Hospice was in compliance with 410 IAC 7-24, Retail Food Establishment Sanitation Requirements, durring their follow-up Sanitation Inspection.	{S 000}		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE